

# APPLICATION FOR ADMISSION

## PERSONAL INFORMATION

Name _____	Today's Date _____
SSN _____ - _____ - _____	Birthdate _____
Address _____ _____	Age _____
Phone _____	Birthplace _____
Occupation _____	Education _____
Last Employer _____	Religion _____
Parish _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Spouse's Name _____	Date of Spouse's Death _____

## MEDICAL INFORMATION

Date of last medical exam _____	Physician's Name _____
Any current diagnosis or conditions, please explain: _____ _____ _____	

## CONTACTS

<b>PRIMARY CONTACT</b>	
Name _____	Home Phone _____
Address _____ _____	Business Phone _____
	Cell Phone _____
Relationship _____	
<b>SECONDARY CONTACT</b>	
Name _____	Home Phone _____
Address _____ _____	Business Phone _____
	Cell Phone _____
Relationship _____	

## HEALTH CARE INFORMATION

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Previous stay in another long term care facility:

Facility \_\_\_\_\_ Dates of Stay \_\_\_\_\_

Reason for discharge \_\_\_\_\_

Previous stay in another long term care facility:

Facility \_\_\_\_\_ Dates of Stay \_\_\_\_\_

Reason for discharge \_\_\_\_\_

Allergies \_\_\_\_\_

## HEALTH INSURANCE

**PRIMARY INSURANCE**

Insurer \_\_\_\_\_

Agreement No. \_\_\_\_\_ Group No. \_\_\_\_\_

**SECONDARY INSURANCE**

Insurer \_\_\_\_\_

Agreement No. \_\_\_\_\_ Group No. \_\_\_\_\_

**PRESCRIPTION COVERAGE:**

Insurer \_\_\_\_\_

Agreement No. \_\_\_\_\_ Group No. \_\_\_\_\_

**OTHER INSURANCE**

Insurer \_\_\_\_\_

Agreement No. \_\_\_\_\_ Group No. \_\_\_\_\_

## REFERRAL SOURCE

NEWSPAPER    PHYSICIAN    CHURCH    SOCIAL SERVICES    FRIEND

OTHER \_\_\_\_\_

## FINANCIAL INFORMATION

All information is confidential. Application cannot be processed without this information.

MONTHLY INCOME	APPLICANT	SPOUSE
SOCIAL SECURITY	\$	\$
SSI	\$	\$
PENSION:	\$	\$
PENSION:	\$	\$
DIVIDEND / INTEREST:	\$	\$
DIVIDENDS / INTEREST:	\$	\$
OTHER MONTHLY INCOME:	\$	\$
<b>TOTAL MONTHLY INCOME</b>	<b>\$</b>	<b>\$</b>

ASSETS	APPLICANT	SPOUSE
CHECKING ACCOUNT: 1.	\$	\$
2.		
SAVINGS ACCOUNT: 1.	\$	\$
2.		
CERTIFICATES: 1.	\$	\$
2.		
STOCKS AND BONDS (MARKET VALUE)	\$	\$
REAL ESTATE (ESTIMATED MARKET VALUE)	\$	\$
NAME ON DEED:		
LOCATION OF PROPERTY:		
LIFE INSURANCE (CASH VALUE)	\$	\$
OTHER ASSETS: 1.	\$	\$
2.	\$	\$
<b>TOTAL ASSETS</b>	<b>\$</b>	<b>\$</b>

LIABILITIES	APPLICANT	SPOUSE
MORTGAGE OR LOAN PAYMENTS	\$	\$
OTHER:	\$	\$
<b>TOTAL MONTHLY INCOME</b>	<b>\$</b>	<b>\$</b>

<b>Does Applicant Have:</b>	<b>YES</b>	<b>NO</b>	<b>Location</b>	<b>Name</b>	<b>Address</b>	<b>Phone</b>
<b>Will</b>						
<b>Power of Attorney</b>						
<b>Durable POA</b>						
<b>Legal Guardian</b>						
<b>Living Will</b>						
<b>Advanced Directives</b>						
<b>Irrevocable Burial Fund</b>						
<b>Choice of Funeral Home</b>						

## **ACKNOWLEDGMENT**

I make this application for residency to Elizabeth Seton Memory Care Center of my own free will. I understand that by making this application, I neither obligate myself to enter the facility, if invited; nor do I hold Elizabeth Seton Memory Care Center responsible for accepting me if for any reason it deems I cannot be received.

Furthermore, it is expressly understood and agreed that the information submitted in this application constitutes the basis upon which I will be considered for residency. Neither the facility nor I are under any obligation until the application has been approved by the facility and the Admission Agreement has been executed.

I certify that all information herein is true and correct to the best of my knowledge. I further understand that any intentional falsification can affect my final or continued occupancy.

I have read or had read to me this completed application and fully understand the same.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

(If applicant is unable to sign)

Relationship to Applicant \_\_\_\_\_

Address of Responsible Party \_\_\_\_\_

Home Phone \_\_\_\_\_

\_\_\_\_\_

Business Phone \_\_\_\_\_